

TRANSMITTAL AND NOTICE OF APPROVAL OF

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

2. STATE:

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

December 16, 2003

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR

7. FEDERAL BUDGET IMPACT:

a. FFY 2004 \$ 3,707 2,279b. FFY 2005 \$ 4,668 2,857

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A pages: 15, 15a, 15b, 15c,
15d, and 16

Attachment 4.19B pages: 2a and 2b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19A pages 15 and 16

Attachment 4.19B pages 2a and 2b

10. SUBJECT OF AMENDMENT: Revised to establish the basis for when inpatient and out-patient hospital services are authorized to be provided out-of-state and the method of reimbursing out-of-state hospitals for inpatient or outpatient care provided to any recipient of Missouri Medicaid, whether they are under twenty-one or age twenty-one and over.

11. GOVERNOR'S REVIEW (Check One):

- ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT *cel*
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Steve Roling

14. TITLE:

Director

15. DATE SUBMITTED:

December 19, 2003

16. RETURN TO:

Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

DEC 22 2003

18. DATE APPROVED:

DEC 22 2003

19. EFFECTIVE DATE OF APPROVED MATERIAL:

DEC 17 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

Steve Roling

21. TYPED NAME:

Steve Roling

22. TITLE:

Director, CMSO

23. REMARKS:

XII. Inappropriate Placements

- A. The hospital per-diem rates as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when he is only in need of nursing home care.
1. If a hospital has an established ICF/SNF or SNF only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF only rate.
 2. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement of nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.
 3. No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

XIII. Out-of-State Hospital Services Reimbursement Plan

- A. Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically necessary care in a semi-private room. If prior authorized Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the recipient requests and is provided a private room when the private room is not medically necessary.
- B. Payment for authorized inpatient hospital services shall be made on a prospective per-diem basis for services provided outside Missouri if the services are covered by the Missouri Medical Assistance (Medicaid) Program. To be reimbursed for furnishing services to Missouri Medicaid recipients, out-of-state providers must complete a Missouri Medical Assistance Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, Division of Medical Services.

- C. Determination of Payment. The payment for inpatient hospital services provided by an out-of-state provider shall be the lowest of:
1. At the out-of-state hospital's election, the prospective inpatient payment may be based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulations for hospitals operating in Missouri with inflationary increases as granted by the Missouri General Assembly or the out-of-state hospital may be exempt from the cost report filing requirements if the hospital accepts the projected statewide average per-diem rate for Missouri hospitals as calculated by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average per-diem rate for Missouri hospitals shall be the first day of the month following the Division of Medical Services determination of per-diem rate based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri.
 2. The amount of total charges billed by the hospital. The provider's billed charges must be their usual and customary charges for services; or
 3. The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program;
- D. Per-Diem Reimbursement Rate Computation. The per-diem reimbursement rate computation is the same as calculated for Missouri hospitals as described in section III.
- E. If a provider fails to submit all financial documentation required by Missouri regulations (Medicare cost report, working trial balance, audited financial statements, Medicaid supplemental schedules and Worksheet C 2552-83 for ancillary costs and charges) for hospitals operating in Missouri within thirty (30) days of making the election to receive payment based on information from cost reports, the payment shall be based on the projected statewide average per-diem rate in Missouri as developed by the Department of Social Services, Division of Medical Services for the state fiscal year.
- F. Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Inpatient hospital services must be submitted on the UB-92 claim form.

- G. Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services.
- H. Disproportionate Share Providers. Out-of-state hospitals do not qualify for disproportionate share (DSH) payments unless they have a low income utilization rate exceeding twenty-five (25) percent for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.
- I. All Medicaid services are subject to compliance reviews. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.
- J. Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.
- K. Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.
- L. Definitions.
 - 1. The definitions as described in section II.
 - 2. Base year cost report - shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.
 - 3. Out-of-state - not within the physical boundaries of Missouri.
 - 4. Usual and customary charge - the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

OUTPATIENT HOSPITAL SERVICES - OUT-OF-STATE HOSPITALS AND FEDERALLY-OPERATED HOSPITALS LOCATED WITHIN THE STATE OF MISSOURI

1. Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Outpatient hospital services must be submitted on the UB-92 claim form.
2. The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the lowest of:
 - A. At the out-of-state hospital's election, a prospective outpatient payment percentage calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports and all documentation required by Missouri regulation for hospitals operating in Missouri regressed to the current state fiscal year or the out-of-state hospital may be exempt from the cost report filing requirement if the hospital accepts the projected statewide average outpatient payment percentage as developed by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average outpatient payment percentage shall be the first day of the month following the Division of Medical Services determination of the outpatient payment percentage based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri.
 - B. The amount of total charges billed by the hospital.
3. Outpatient Reimbursement Rate Computation. The outpatient reimbursement rate computation is the same as calculated for Missouri hospitals as described in section I.

LAB AND X-RAY SERVICES (INDEPENDENT)

The state agency will establish fee schedules based on reasonable charges for services as defined and determined by the Division of Medical Services in accordance with the methods and standards of 42 CFR 447 Subpart D. The agency payment will be the lower of:

1. The provider's actual billed charge, or;
2. The allowable fee based on reasonable charge as above determined.

For certain specified diagnostic laboratory services included under the Title XVIII Medicare fee schedule the Medicaid payment will not exceed the maximum allowable Medicare payment.

- K. Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services to Medicaid eligible recipient age twenty-one (21) and older.
- L. Disproportionate Share Providers. Out-of-state hospitals do not qualify for disproportionate share (DSH) payments unless they have a low income utilization rate exceeding twenty-five (25) percent for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.
- M. All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.
- N. Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.
- O. Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.
- P. Definitions.
 - 1. The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.180.
 - 2. Base year cost report - shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.

3. Emergency medical condition - a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 - a. Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - b. Serious impairment to bodily functions;
 - c. Serious dysfunction of any bodily organ or part;
 - d. Serious harm to self or others due to an alcohol or drug abuse emergency;
 - e. Injury to self or bodily harm to others; or
 - f. With respect to a pregnant woman having contractions:
 - (1) That there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (2) That transfer may pose a threat to the health or safety of the woman or the unborn.
4. Medically necessary - hospital service that is consistent with the recipient's diagnosis or condition and that is in accordance with the criteria as specified by the department. Services will be provided in the most cost effective and appropriate setting and shall not be provided for the convenience of the recipient or the service provider.
5. Out-of-state - not within the physical boundaries of Missouri.
6. Usual and customary charge - the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

- XIV. Reimbursement for inpatient hospital services associated with an admission for the surgical performance of only those human organ and bone marrow transplantations as defined in Attachment 3.1-E is made on the basis of reasonable cost of providing the services as defined and determined by the Division of Medical Services.

The methodology defined in this attachment in Sections I. through XIV. for all other inpatient hospital services reimbursement is not applicable to these specific services. Inpatient hospital costs associated with these services are excluded from the per-diem reimbursement rate computation.

State Plan TN# 03-20
Supersedes TN# 97-15

Effective Date 12/16/03
Approval Date JUL 28 2004

The state agency will reimburse providers of Lab and X-Ray Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

FAMILY PLANNING

The state agency will pay for medical services which are identified as qualified Family Planning services. The payment will be in accordance with the standards and methods herein described as apply to the provider type represented

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (E.P.S.D.T.)

Reimbursement for EPSDT services provided in accordance with the provisions of section 6403 of P.L. 101-239 and federal regulations as promulgated thereunder shall be made on the basis of reasonable allowance fee schedules or per-diem rates, if applicable, as determined by the Division of Medical Services, and in accordance with the standards and methods herein described as applicable to the service and provider type represented. The state payment for each service will be made on the lower of :

- (1) The provider's actual charge for the service, or;
- (2) The maximum allowable fee or rate as determined by the Division of Medical Services.